361998423 Clinical Psychology Notes

General Psychology (San Diego Mesa College)

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TOPIC 1: INTRO TO CLINICAL PSYCHOLOGY

CLINICAL PSYCHOLOGY

- Field of Clinical psychology integrates science, theory and practice to understand and alleviate
- Helps people with disabilities or disorders to adapt with science, theory and practice

ACTIVITIES OF CLINICAL PSYCHOLOGISTS

- Therapy / Intervention*
- Diagnosis / Assessment – to identify problem*
- Teaching
- Clinical Supervision
- Research
- Consultation – asking for help / advice from colleagues (2nd opinion)
- Administration

BECOMING A CLINICAL PSYCHOLOGIST: *PHILIPPINE SETTING*

A professional psychologist shall be **authorized** to engage in the professional practice of psychology consisting of the delivery of psychological services:

a. Psychological Interventions

HISTORY

- Philosophy roots
- Reformed movements in the 19th Century
- Philippe Pinel, French Physician – “makatao” : moral therapy
- William Tuke, Englishman – Morality therapy
- Eli Todd, American : mga paglalagyan (hindi pa mga asylums)
- Dorothea Dix, American – Established the mental asylums

DEVELOPMENT IN SPECIFIC AREA

- Diagnosis & Assessments (1850-1899)
    - Francis Galton, Englishman – Anthromorphic Lab : Look at individual capabilities/abilities
    - James McKeen Cattell, American – used statistical methods
    - Emil Kraeplin – psychodiagnposis book
    - Binet – Binet-Simon Scale
    - Carl Jung – association method (uncover unconscious complexes)
    - Kent – Rosanoff Free Association Tests (1910)
    - Charles Spearman – g (general intelligence)
    - Army Beta Test (1917) – abilities
    - Robert Woodworth – first personality test; Psychoneurotic Inventors; World War personal Data Sheets
    - 1914 Terman
    - 1921 Rorschach
    - 1935 TAT

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- 1937 Project Technology
- 1939 WBIS
- 1943 MMPI
- 1949 Halstead NTB
- 1952 DSM I
- 1968 DSM II
- 1970 Behavioral Assessment
- 1980 DSM III
- 1980s Personality Assessment
- 1987 DSM III-Revised
- 1990s Managed health care impact
- 1994 DSM IV

SIGNIFICANT EVENTS IN THE INTERVENTION

- 1793 – Pinel – Humane Care
- 1848 – Dix – established Asylum
- 1895 – Breur & Freud – Hysteria Studies
- 1900 – Interpretation of Dreams
- 1908 – Clifford Beers – Mental Hygiene Movement (patient)
- 1909 – Healy – Child Guidance in Chicago
- 1920 – Watson & Raynor – little albert experiment – irrational behavior = unlearn
- 1932 – Moreno – Group Therapy – healing process, enhance treatment
- 1950 – Dollard & Miller – personality & psychotherapy
- 1951 – Rogers – Client-centered Therapy; Eynseynk & Skinner
- 1958 – Wolpe – Systematic Desensitization
- 1965 – Community Psychology – prevention then co
- 1980s – Health Psychology – application of health principles of health illnesses
- 1990s – managed Health Care Impact
- 1995 – Empirically support treatment (research-based)

SIGNIFICANT EVENTS IN RESEARCH

- 1879 – Wundt – Father of Modern Psychology
- 1890 – William James Concepts of Consciousness
- 1905 – Binet & Simon
- 1939 – Terman's research on Binet Scale
- 1943 – Weschler's research on W-Bellev
- 1952 – MMPI data gathered by Hathaway & McKinley (2k-3k Pts with Mental Distorder)
- 1954 – Rogers & Dymond's Research on the counselling process; Rotter publishes his Social Learning Theory
- 1977 – Smith & Glass Meta-Ana & Psychotherapy

PROFESSION OF CLINICAL PSYCHOLOGY

- 1907-1935 **– LIGHTNER WITMER** - Founder of the first journal in Clinical Psychology "The Psychological Clinic"; Develop the first training program in CP in University of Pennsylvania

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- 1892 – APA was founded with G. Stanley Hall as President
- 1896 – Name field Clinical Psychology as a subfield in the field of Psychology
- University of Pennsylvania
- 1947 – ABEPP
- 1949 – Boulder Conference – Scientist – Practitioner Model
- 1953 – APA publishes Ethical Standards
- 1963 – Psy. D Program
- 1981 – Revised Ethical Standards
- 1988 – APS founding
- 1992 – Revision of Ethical Principles
- 1995 – APA endorses prescription privileges for psychologist (CP can prescribe medicines)

CURRENT ISSUES IN CLINICAL PSYCHOLOGY

- MODELS OF TRAINING IN CP – ways on how a psychology professionals could become a Clinical Psychologist
    - **Scientist – Practitioner Model** – attempt to "marry" science & Clinical Practice; Focus training on empirically supported approaches to assessment, prevention and clinical intervention.
    - **Doctor of Psychology (Psy.D) Degree** - Emphasizes on the development of clinical skills & relative deemphasize on research competence; not so much in research
    - **Professional Model** – No affiliation with schools, autonomous with own financial & organizational framework; emphasize Clinical function; no research orientation
    - **Clinical Scientist Model -** integrating scientific principles on their own clinical work
    - **Combined Professional-Scientific Training Program** – combined specialty in all fields (clinical,industrial & school)
- **Graduate Programs** – Past & Future
    - Shift from university-based academic jobs to jobs in private practice (because of Professional Model & Psy. D)
    - Oversupply of practice-oriented psychologists (one's foundation in psychology.. is it enough?)
    - Manage health care (health cards covered the mental health) revolution reliantly affect the demand for Clinical Psychologist and the curriculum in training programs

PROFESSIONAL REGULATION

- **Certification** – relatively weak form of regulation: certifying to be illegible of practicing CP; Professional Models
- **Licensing** – stronger; exams are taken

PRIVATE PRACTICE

- Emphasis on restrictive legislation, diplomas & political activism
- De-emphasis on research
- Insurance coverage, professional rivalry with psychiatry (prescription privilege) & statutory regulation
- Managed health care dominates the scene
- Independence & Economics
- Right to practice independently

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- Psychotherapy began to be covered health plans & practitioners eligible for reimbursement
- Less scholar & more entrepreneur (naging business yung pagiging psych & as is yung mga binibigay na treatment)

IMPACT OF HEALTH CARE REVOLUTION

- Control cause and use of services while at the same time ensuring their quality (standard rates) : Effective intervention (mga research based)
- Dictates definition of what constitutes psychological treatment
- Most changes will occur outside treatment (after treatment effects)
- Resources will be used in greater effect

PRESCRIPTION PRIVILEGES

- Work of a psychiatrist and not a psychologist
- Psychologist : psychological intervention
- Psychiatrist: medical
- Uniqueness of CP is tampered

PROS	**CONS**
Provide a wide variety of treatments	De-emphasis on psychological forms of treatment
Offer services to lots of clients; not limited on nature of clients	Damaged relationship with psychiatry (because of the overlapping of role)
Potentially increase in cause effectiveness of care for patients who need both psychological treatment and medication	Increase in malpractice in liability costs
Competitive edge for CP in clinical market	Culturally sensitive mental health services
Natural progression of Clinical Psychologist task is to become a full pledged health care profession	

ETHICAL STANDARDS

- PRINCIPLES
  - Beneficence (anything that the professional does, it has to benefit the client) & Non-Malefiscence (Shouldn't harm the client)
  - Fidelity (faithfulness) & Responsibility
  - Integrity
  - Justice(fair)
  - Respect for people's rights and dignity
- ISSUES
  - Competence – making sure what you are doing is your expertise; right service to client
  - Privacy and confidentiality – do not divulge in information
    - Can only divulge in information (or confidentiality can be broken if and only because of the ff)
      a. Consulting with fellow colleagues
      b. If the court orders to
      c. If the client has motives on harming the self or other people
  - Human relations
    - Dual Relationship

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RESEARCH METHOD IN CLINICAL PSYCHOLOGY

- **Observation**
  - Unsystematic Observation : no structure
  - Naturalistic Observation: you know what to observe & what your target is
  - Controlled Observation – done in the lab; specific & known behavior
  - Case Studies
- **Epidemiological Research**
  - Used in medical research
  - Simple counting of cases
  - Important in identifying groups of individuals who are at risk
- **Correlation Methods**
  - Determining whether *variable x is related to variable y*
  - *Example.* Anxiety & feelings of lack of control (aggression with violent shows)
- **Cross-Sectional**
  - Evaluates / compares individuals, perhaps of different age group at the same point in time
- **Longitudinal**
  - Follows the same subject over time
- **Experimental**
  - Determine cause-effect relationship among events
  - **Control Group**
  - **Experimental Group**
- **Single Case Designs**
  - Outgrowth of behavioural & operant approaches
  - Compare the baseline level of behavior with post-intervention level
- **Mixed Design**
  - Correlational & Experimental

RESEARCH & ETHICS

- **Informed Consent** – ask permission to participant if involve on research
- **Confidentiality** – all information = confidential
- **Deception –** to get genuine behavior and results that you want
- **Debriefing** – tell kung ano yung research and information na maguunearth
- **Fraudulent Data** – Don't manipulating the data

TOPIC 2 : DIAGNOSIS & CLASSIFICATION OF PSYCHOLOGICAL PROBLEMS

ABNORMAL BEHAVIOR

- Conformity to norms – statistical infrequency / violations of social norms
  - ✓ Advantage: cut-off points and intuitive appeal
- Subjective Distress – felt when something is wrong
- Statistical Abnormality – limitations
- Disability/Dysfuction – Mental Illness definition

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*always consider the context/cultures

- DSM 5 Definition: A clinically significant behavioural or psychological syndrome or pattern that occurs in an individual and that is associated with present distress or disability or with a significantly increased risk of suffering death pain or disability or an important loss of freedom.
    - It is a group of symptoms which are associated with a present distress

HISTORY OF DSM

- 1952 has a total of 106 disorders across several major categories.
- 1968 DSM-II which increased to 182 disorders
- 1980 DSM-III
- 1987 DSM-III Revised
- 1994 DSM-IV
- 2000 DSM-IV-TR
- 2013 DSM-5
- MAJOR CHANGES
    - Used Multi-axial System in which you have to go through 5 accesses to diagnose
        - Access 1: Identify clinical disorder
        - Access 2: Identify Personality disorder
        - Access 3: Identify Medical disorder
        - Access 4: Societal factors (divorce, death, separation, etc.)
        - Access 5: General Affective Functioning
        - But these are currently not used anymore
    - No more roman numerals
    - Removes OCD and is categorized into its own category with sub disorders

    *Get copy from Ms. Corado because its too long.

- DIAGNOSIS
    - Positive Aspects
        - Facilitates communication (verbal shorthand)
        - Ensures comparability among identical patients
        - IMPORTANCE
            - Communication
            - Enables & Promotes empirical research in psychopathology
            - Research into etiology becomes possible
            - Suggests which mode of treatment is likely to be effective

    - Negative Aspects:
        - Gender Bias
        - Negative perception with person with mental illness/disorder
        - Boundaries between disorders are often fuzzy
            - Thin line of difference between the different disorder symptoms

- CAUSES OF ABNORMAL BEHAVIOR:

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- Biological – genetic, inheritance, brain function & chemical imbalances
- Psychodynamic – trauma (personalities associated with this: Psychoanalytic: Freud)
  - Unconscious materials that would dominate the individual without having control of it.
  - Early childhood experiences that caused trauma in an individual
- Learning – (Behaviorist: Pavlov, Skinner)
  - Behaviors are learned
  - Classical conditions
  - Operant principles: Rewards and punishments
- Cognitive – (Bandura)
  - Role of thinking in our behavior
- Humanistic – (Maslow, Rogers)
  - Maslow: Hierarchy of Needs
  - Rogers: Growth – receive or experience acceptance
- Sociocultural – standards of the society

TOPIC 3

CLINICAL ASSESSMENT

- Involves an evaluation of an individual's strengths and weaknesses, a conceptualization of a problem at hand, as well as possible etiological factors and some prescription for alleviating the problem, all of these lead us to a better understanding of the client.
- Basis for clinical assessment – REFERAL QUESTION
  - **REFERAL QUESTION** – goal or the objective of the assessment from those that referred the client
  - Variety of tools
    - Psychological tests
    - Observation
    - Case studies
    - Case histories
    - **INTERVIEW**

– It is an interaction between the client and assessor (active involvement from both parties)

Client: open and offers information

Assessor: open and asks questions to get the information she needs

Interaction = *EGALITARIAN*: assessor is NOT superior over the client and vice versa

- **INTERVIEW VS TESTS**

INTERVIEW	TESTS
You could probe, confirm and clarify the information	Take the information as it is
Come up with own conclusion	
Able to gather more information	

Clinical Interviewing is an ART because of the structured questions asked and the type of interview

- **INTERVIEW ESSENTIALS AND TECHNIQUES**

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- PHYSICAL ARRANGEMENT: no barriers, not facing each other, well-lighted room, not so much decorations, the watch should not be seen by the client (so it is behind the client)
- NOTE TAKING & RECORDING: consider the comfort of the client. Do the note taking after or ask for permission from the client.
- RAPPORT: establishment of the relationship (Rogers) Empathy, Unconditional Positive Regard and Genuineness to communicate with the client and to consider the comfort during the session

- COMMUNICATION – 2 way
  - Client barriers should be broken to get to understand the client
  - Language should be appropriate within the level of the client's maturity
  - Questions are recommended to **OPEN ENDED QUESTIONS** *(this would generate more information)*; **Close ended questions** should be followed by a 'why' or a 'how'
  - Silence would tell us something about the client
  - Listening skills should be used (listening skills: paraphrasing, clarifying, reflecting on content and emotion, summarizing) not only with our hearts but also with our ears.
- Impact of the Clinician
  - Is the clinician Open or Genuine?
  - Delivery of questions
  - How does the clinician listen
  - This will affect how the course of the interview will go.
  - The entire personality of the clinician will affect the whole interview
- Values and Background of the Clinician
  - Should have ***personal maturity*** (based on experiences); being vicarious or not (wala mang experience pero may alam)
- Patient's frame reference
  - Use the perspective of the patient to understand where he or she is coming from without bringing your own judgement to not translate it differently. (para hindi bias)
  - Needs to be *as it is*
- Clinician's frame of reference
  - Use of CLINICIAN'S Judgement
  - Using the knowledge about human behavior, principles of psychology, and psychological problems in terms of judging to understand the information given by the client
    - It is objective due to the theoretical background

- **VARIETIES OF INTERVIEW**
  - **INTAKE-ADMISSION INTERVIEW**
    - Prior to admission
    - Interviewer checks the symptoms and difficulties that the patient goes through (the condition)
    - Ask the client "why are you here" to know his expectations. This will lead to telling the services that you offer and their fees.

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- Patient's percentage complaints, the steps he has taken previously.
- Purpose: to develop a better understanding of the patient's symptoms or concerns in order to recommend the most appropriate treatment or intervention plan
- End: either admitting or not the client/referral

- **CASE HISTORY INTERVIEW**
  - It will cover the entire history of the client in all the aspects of his life
  - Personal social history interview
  - Patient's early life, with particular attention paid to family relationship and general environment, educational and vocational history, neuropathic traits, habits and recreations.
- **MENTAL STATUS EXAMINATION**
  - Mental condition of the patient
  - Awareness of the person (time, date, place, and more)
  - Oriented or not
  - Concentration of the patient
  - If the patient's answer is parallel to the clinician's question (whether it answered the question or not)
  - The client should have clear thoughts and calm emotions
- **CRISIS INTERVIEW**
  - To classify that the patient wouldn't harm him or herself
  - Engaging the patient to be at ease
  - Patient is in the middle of a significant and often traumatic or life threatening crisis
- **DIAGNOSTIC INTERVIEW**
  - Questions checking on the symptoms to diagnose
  - It is based on DSM-5, if the symptoms are on the client.

TOPIC 4: BASIC THEORIES OF FREUD

FREUD – PSYCHOANALYSIS ***Refer to the Concept Maps*****

GOALS OF INTERVENTION

- Help clients become more aware of the unconscious aspects of their personalities. Make the unconscious conscious.
- Work through unresolved developmental stages
- Strengthen the ego
- Cope with the demands of the society

ROLE OF THE COUNSELOR/THERAPIST

- Play the role of expert
- Encourage client to choose topic to talk about, especially childhood experiences
- Attempt to create comfortable atmosphere
- Encourage development of transference

PROCESS TECHNIQUES

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- Free Association – letting the client talk about anything or everything; **Non-judgemental** listening
- Dream Analysis – let the client talk about his or her dream and we interpret the dream
- Analysis of Transference – to establish the rapport and let the client listen to you and follow you; it will let you understand the person's behavior and his or her relationship with others
- Analysis of Resistance – the client may avoid the topic this may have a meaning; If there is resistance = cannot talk
- Interpretation – active; relate/connect to current interpretation
    - Used in psychodynamic theory
    - All of these are dependent on the therapist

MULTICULTURAL & GENDER SENSITIVE ISSUES

- Has transcended cultural barriers – it answers multicultural issues
- Concepts seem to have relevance for different parts of society – continues to be relevant even though evolution has been made throughout the generations
- Many women avoid psychoanalysis – (Freud's psychoanalysis is bias to men)

STRENGTHS & CONTRIBUTIONS

- Emphasizes importance of sexuality & unconscious
- Heuristic – because of this theory, more theories sprouted
- Theoretical base of support for diagnostic instruments – Basis of projective techniques and used in case interview
- Reflects complexity of human nature
- Has developed over years, not stagnated
- Effect for a wide variety of disorders
- Stresses importance of developmental growth stages

LIMITATIONS & CRITICISMS

- Time consuming & expensive – it will not be finished until the client tells you that he or she is okay already
- Difficulty with older clients – struggles to alter the point of view of the client from their *younger days* experiences
- Claimed almost exclusively by psychiatry
- Overly complicated terminology
- Deterministic
- Not appropriate for most individuals who seek professional counselling – counselling gives options or solution, if not you the client will. It should be gaining insight and self awareness

THERAPEUTIC PROCESS

HUMANISTIC APPROACH

- **MASLOW –** hierarchy of needs
- **ROGERS – person-centered approach:** core conditions (Unconditional Positive Regard [Accepted or Rejected], Congruence (Genuineness) and Empathy

PERSON-CENTERED THEORY

- Based on concepts from humanistic psychology (specifically Roger's theory)

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- Some of the concepts are based from the theory of Rollo May
- **Development of the approach**
  - Non-directive counselling: depends on client
  - Emphasized the counsellor's creation of a permissive & non-directive climate
  - 1st Period: Focused on reflecting the client's verbal and non-verbal communications with the aim of helping clients become aware of and gain insight (due to incongruence) into their feelings
  - 2nd Period (1950s) renamed to *Client-Centered Theory* – characterized by a shift from classification of feelings to a focus on the phenomenological world of the client
  - 3rd (1950s-1970s) conducted researches on the client-centered approach processes and outcomes
  - 4th (1980s-1990s) expansion to education, industry, groups, conflict resolution and search for world peace = person-centered approach

THERAPEUTIC GOALS - achieve a greater degree of independence and integration by:

- Focus on the person, not on the person's presenting problems
- Assist clients in their growth process so client could better cope with their current and future problems
- To provide a climate conducive (environment that provides the 3 core concepts) to helping individuals to become fully functioning person

ROGERS (1961) described people who are becoming increasingly actualized as having:

1. Openness to experience – willing to do an amount of risk for a good reason
2. Trust in themselves – ability to cope with situation; anchored on one's capabilities
3. Internal source of evaluation – able to see what is right and wrong; what is one's capabilities, weaknesses
4. Willingness to continue growing – effort to grow

*encouraging these characteristics is the basic goal of the PCT

FUNCTION & ROLES OF THERAPIST

- Rooted in being & attitudes, not in techniques designed to get the client to "do something": *Main tool is the <u>therapist</u>*
- Therapist use themselves as the instrument of change
- To be present and accessible to clients and to focus on their immediate experiences; you create the environment.
- Avoids:
  - ∅ Case History
  - ∅ Whys
  - ∅ Interpretation on client's behavior
  - ∅ Evaluate a client's ideas/plans
  - ∅ Length/frequency of the therapy – client will tell us that "I'm okay" thus sesh will end

CLIENT'S EXPERIENCE IN PCT

- State of incongruence
- Explore a wider range of beliefs & feelings
- Distort less & move to a greater acceptance and integration of conflicting and confusing feelings (listening skills are used)
- Experience freedom to be who they are – focus on their experience in subjective field

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- Increase freedom √ mature psychologically and more actualized
- Self-healing capacities are activated – the client will feel the alternative and positive emotion from the therapy itself; all essential conditions will activate every feeling of acceptance

RELATIONSHIP BETWEEN THERAPIST AND CLIENT

1. There is psychological contact – Client: to be real, to be the self, 2 people engaged in psychological fear; Clinician: open and present
2. Client being incongruence being vulnerable or anxious and Therapist is congruent, will or genuine
3. Therapist experiences UPR for the client -18:11
4. Genuineness or congruence & UPR

Accurate empathic understanding

Experience Arts Therapy

Last 18 minutes

TOPIC 5: LEARNING

Bandura – Observational Learning

Skinner – Operant Conditioning

Pavlov – Classical Conditioning

- Behavior is learned

View of human nature

- The person is the producer and the product of his or her environment *person is capable of producing a behavior
- 6 key characteristics of Behavior Therapy
  1. BT is based on the principles and procedures of the scientific method
  2. BT deals with the client's current problems and the factors influencing them, as opposed to analysis of possible historical data *past doesn't matter. *what matters is the symptoms that is showing now.
  3. Clients involved in BT are expected to assume an active role by engaging in specific actions to deal with their problems. *person is actively playing its part when it comes to their experience in life. *During this therapy, you are going to do something about the problem to solve your problem actively
  4. BT assumes an approach that change can take place without insight into underlying dynamics. *insight is not the main focus but the CHANGE in behavior itself *to produce healthy behavior
  5. BT focuses on assessing overt and covert behavior *directly, identifying the problem*, and *evaluating changes*.*walang hidden behavior or meaning *no certain techniques to uncover hidden meanings
  6. Behavioral treatment interventions are individually tailored to specific problems experienced by client. * treatment is tailored to the problem or situation or fear
- Therapeutic Process
  - GENERAL GOAL: to increase personal choice and to create new conditions of learning

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- The client with the help of the Therapist defines specific treatment goals at the outset of the therapeutic process. *supports the main goal *by taking part and establishing the treatment goal
- Goals must be clear, concrete, understood, and agreed on by the patient and the Therapist *Egalitarian relationship

- Therapist function and role
  1. Therapist formulates initial treatment goals and designs and implements a treatment plan to accomplish these goals
  2. Therapist uses strategies that have research support for use with a particular kind of problem
  3. Therapist evaluates the success of the change plan by measuring progress toward the goals throughout the duration of the treatment. *constant and consistent monitoring of the patient
  4. Therapist conduct follow-up assessment to see whether the changes are durable over time.
- Client's Experience in therapy
  1. The client engages in behavioural rehearsal *(practicing of new set of learning) with feedback until skills are well-learned and generally receives active homework assignments *Client being active
  2. Changes clients have in therapy are translated into their daily lives *behavior that is manifested should not only be stable in a particular aspects but in different aspects in life
  3. Clients are motivated to change and are expected to cooperate in carrying out therapeutic activities, both during therapy sessions & in everyday life *sense of responsibility
  4. If clients are not motivated, they undergo motivated interviewing *increase of motivation dapat
  5. Clients are encouraged to experiment for the purpose of enlarging their repertoire of adaptive behavior *habits
  6. Clients are aware when the goals have been met *the client ends the therapy session with him solving the problem

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